Your Anthem Benefits

Anthem

State of Indiana Benefits Comparison Summary of Benefits for 2007

	HEALTH SAVINGS ACCOUNT HDHP PLAN I	HEALTH SAVINGS ACCOUNT HDHP PLAN II	*TRADITIONAL PLAN II	TRI-CARE COMPANION PLAN
Deductible (Single/Family) *(Applies only to percent (%) coinsurance) Deductibles are co-mingled Network and Non-network)*	$ 2,500 single Network/Non-network $ 5,000 family Network/Non-network Family Coverage requires the family deductible to be met before coinsurance applies. The single deductible DOES NOT apply to family coverage With Tobacco Incentive: $ 2,000 single Network/Non-network $ 4,500 family Network/Non-network Family Coverage requires the family deductible to be met before coinsurance applies. The single deductible DOES NOT apply to family coverage	$ 1,700 single Network/Non-network $ 3,400 family Network/Non-network Family Coverage requires the family deductible to be met before coinsurance applies. The single deductible DOES NOT apply to family coverage With Tobacco Incentive: $ 1,200 single Network/Non-network $ 2,900 family Network/Non-network Family Coverage requires the family deductible to be met before coinsurance applies. The single deductible DOES NOT apply to family coverage	$500 single Network/Non-network $500 family Network/Non-network Deductible applies to Prescription Drugs With Tobacco Incentive: $0 single Network/Non-network $0 family Network/Non-network	$0 single $0 family
Out of Pocket Maximum (Single/Family) Out of pockets are co-mingled Network and Non-network	$4,000 per enrollee $8,000 per family Includes the deductible Rx co-pay(s) do accrue to out of pocket	$2,400 per enrollee $4,800 per family Includes the deductible Rx co-pay(s) do accrue to out of pocket	$2,000 per enrollee $4,000 per family Includes the deductible Rx co-pay(s) do not accrue to out of pocket	N/A per enrollee N/A per family Rx co-pay(s) do not accrue to out of pocket
	Note: The out of pocket maximum limit accrues on a calendar year basis. After the out of pocket limit has been met, benefits are paid at 100% of covered charges for the remainder of that calendar year.	Note: The out of pocket maximum limit accrues on a calendar year basis. After the out of pocket limit has been met, benefits are paid at 100% of covered charges for the remainder of that calendar year.	Note: The out of pocket maximum limit accrues on a calendar year basis. After the out of pocket limit has been met, benefits are paid at 100% of covered charges for the remainder of that calendar year.	
Professional Office Services Including allergy – testing and treatment – serum and injections	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit	$20 Network/40% Non-network per visit	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Preventative Care Services Services include: Immunizations for eligible dependents, annual physicals for employees and their eligible covered dependents, flu shots, annual pap smears and diagnostic services performed with the annual physical. This benefit does not include inpatient services or surgical procedures.	Covered In Full Network/40% Non-network In-Network is Not subject to deductible	Covered In Full Network/40% Non-network In-Network is Not subject to deductible	$20 Office Visit Co pay Network/ 40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Medical Supplies, Equipment & Appliances	20% Network/40% Non-network	20% Network/40% Non-network	* 20% Network/40% Non-network Subject to deductible	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.

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Maternity Services	20% Network/40% Non-network	20% Network/40% Non-network	$500 Network/40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Inpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	$500 Network/40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Outpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	$250 Network/40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Professional Inpatient/Outpatient Services	20% Network/40% Non-network	20% Network/40% Non-network	Covered in full after deductible Network/40% Non-network Subject to deductible	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Emergency and Urgent Care: • Emergency Care in ER Room • Urgent Care Facility	20% Network/20% Non-network	20% Network/20% Non-network	$75 Network or Non-network $35 Network or Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Ambulance	20% Network/20% Non-network	20% Network/20% Non-network	$50 Network or Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Radiation/Inhalation Therapy	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Co-pay Network/ 40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits Speech therapy: 25 visits	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Co-pay Network/ 40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.

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Mammogram Includes 1 per person, per calendar year. Additional mammography services and ultrasounds are covered as determined medically necessary by your physician. **Routine Prostate Antigen Tests (PSA)** Includes 1 per person, per calendar year Colorectal Cancer Exam/Laboratory Testing	Covered in full Network/40% Non-network Not subject to deductible	Covered in full Network/40% Non-network Not subject to deductible	$20 Office Visit Co-pay Network/ 40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Diabetes Self Management Training	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Co-pay Network/ 40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Diagnostic Services (i.e. lab, x-ray, MRI)	20% Network/40% Non-network	20% Network/40% Non-network	Covered in full after deductible Network/ 40% Non-network Subject to deductible	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Temporomandibular Joint (TMJ) Services • Outpatient Facility • Provider Individual • TMJ Surgery - Professional Services • TMJ Other Services	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)	 $250 Co-pay Network/40% Non-network $20 OV Co-pay Network/40%Non-network Professional Outpatient Services Subject to deductible Covered in full after deductible Network/40% Non-network $2,500 lifetime maximum for all services (Network/Non-network)	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Hospice	20% Network/20% Non-network	20% Network/20% Non-network	20% Network/20% Non-network Subject to deductible	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Home Health Care No RN/LPN unless billed through a Home Health Care Agency	20% Network/40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee	20% Network/40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee	$20 Co-pay per day Network/ 40% Non-network Private Duty Nursing limited to $5,000 plan maximum per enrollee	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Home IV Therapy	20% Network/40% Non-network	20% Network/40% Non-network	$20 Co-pay per day Network/ 40% Non-network	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Employee Assistance Program	Provides consultation and referral services for personal concerns for employees and their household members.	Provides consultation and referral services for personal concerns for employees and their household members.	Provides consultation and referral services for personal concerns for employees and their household members.	Provides consultation and referral services for personal concerns for employees and their household members.

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Managed Mental Health including Substance Abuse Covered Same as Any Other Condition	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	20% Network/40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	$500 Inpatient Co-pay Network/ 40% Non-network $20 Office Visit Co-pay Network/ 40% Non-network Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000. Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed
Human Organ and Tissue Transplants (HOTT) Specialty Network	20% Network/40% Non-network See contract for other maximums and exclusions	20% Network/40% Non-network See contract for other maximums and exclusions	$2,000 Network/40% Non-network See contract for other maximums and exclusions	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Lifetime Maximum includes Human Organ and Tissue Transplants (HOTT)	$2 million Network and Non-network combined	$2 million Network and Non-network combined	$2 million	Covered in full up to $150 Single or $300 Family. Benefits after $150 Single or $300 Family covered at 25% up to calendar year maximum of $3,000.
Prescription Drug Options: Network Tier structure equals 1/2/3 (and 4, if applicable) Including Birth Control	Network / Non-network	Network / Non-network	Network / Non-network $500 deductible applies Co-pays apply after deductible satisfied	Network / Non-network Plan Pays
Network Retail Pharmacies:	Tier 1 10% 40% Tier 2 20% 40% Tier 3 & 4 40% 40%	Tier 1 10% 40% Tier 2 20% 40% Tier 3 & 4 40% 40%	Tier 1 $10 40% Tier 2 $20 40% Tier 3 & 4 40% 40% (min.$40; max.$100)	Tier 1 $ 3 $ 3 Tier 2 $ 9 $ 9 Tier 3 & 4 $22 $22
Anthem Rx Direct Mail Service: The network penalty will be waived if there is not a network pharmacy within 12 miles of the participant's home. Tier 1 – Preferred Prescription Drugs Tier 2 – Preferred Prescription Drug Tier 3 - Non-Preferred Prescription Drug Tier 4 – Prescription Drugs (mostly injectable drugs	Tier 1 10% Not covered Tier 2 20% Tier 3 & 4 40% Not covered Network Retail Pharmacies: up to a 34-days supply of medication or 100 units Anthem Rx Direct Mail Service: up to a 90 day supply	Tier 1 10% Not covered Tier 2 20% Tier 3 & 4 40% Not covered Network Retail Pharmacies: up to a 34-days supply of medication or 100 units **Anthem Rx Direct Mail Service:** up to a 90 day supply	Tier 1 $20 Not covered Tier 2 $40 Tier 3 & 4 40% Not covered (min. $80; max. $150) The prescription drug co-pays do not apply to the medical out of pocket. Network Retail Pharmacies: 100% of allowable cost after co-payment up to a maximum of 34-days supply of medication or 100 units Anthem Rx Direct Mail Service: 100% of allowable cost after co-payment up to a maximum 90 day supply	Tier 1 $ 3 Not covered Tier 2 $ 9 Not covered Tier 3 & 4 $22 Not covered Network Retail Pharmacies: up to a 34-days supply of medication or 100 units **Anthem Rx Direct Mail Service:** up to a 90 day supply

See Benefit Booklet for exclusions

Notes:

- Dependent age: to end of the calendar year after the child's 19th birthday; or to the end of the calendar year after the child's 23rd birthday if the Dependent qualifies as a Full Time Student.
- No deductible carry over credit
- All out-of-network charges that require a 40% co-insurance are subject to the deductible.

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.